

**KENTUCKY BOARD OF PHARMACY**  
**PHARMACIST PRECEPTOR'S AFFIDAVIT**

**Form II** must be submitted in **duplicate** within **ten (10) days** from the beginning of internship.  
Form II must be **resubmitted** in duplicate within ten (10) days if **change in Pharmacist Preceptor**.  
Please mail certified, return receipt requested to:

KENTUCKY BOARD OF PHARMACY  
SPINDLETOP ADMINISTRATION BLDG., STE 302  
2624 RESEARCH PARK DRIVE  
LEXINGTON, KY 40511  
PHONE 859-246-2820 FAX 859-246-2823

Pharmacist Intern's Name \_\_\_\_\_

Pharmacist Intern's ID Number \_\_\_\_\_

Pharmacist Preceptor's Name \_\_\_\_\_

Pharmacist Preceptor's License Number \_\_\_\_\_ State of Licensure \_\_\_\_\_

Full Name and Address of Pharmacy \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Permit Number \_\_\_\_\_

Pharmacist Intern's Starting Date \_\_\_\_\_

- ❖ I shall maintain personal supervision of the Pharmacist Intern on a one-to-one basis and fully understand that a Pharmacist Intern cannot legally compound or dispense prescriptions except when doing so under the immediate, personal supervision of a certified pharmacist preceptor and may not be left in charge of a pharmacy.
- ❖ I affirm that I will adhere to the requirement of the "Pharmacy Internship Policy" and the requirements of Kentucky law and administrative regulations.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Pharmacist Preceptor's Signature)

**(It is the Pharmacist Intern's responsibility to submit this form to the Kentucky Board of Pharmacy office within the required time limitation.)**